

APPEAL NO. 93140
FILED APRIL 12, 1993

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq.* (Vernon Supp. 1993) (1989 Act). A contested case hearing was held on November 16, 1992, with (hearing officer) presiding, to determine when the respondent (claimant) reached maximum medical improvement (MMI) and what was his impairment rating. The hearing officer accorded presumptive weight to the report of the doctor designated by the Texas Workers' Compensation Commission (Commission) to examine claimant, which stated that claimant reached MMI on July 22, 1992, the date of the examination, and assigned him a whole body impairment rating of 18% for his lumbar spine injury. The appellant (carrier) challenges that MMI date because claimant had been refusing surgery since November 1991 and his condition remained unchanged from that time. The carrier also challenges the 18% impairment rating on the grounds that the designated doctor failed to use the particular version of the Guides to the Evaluation of Permanent Impairment (AMA Guides) mandated by Article 8308-4.24, delegated claimant's evaluation to another doctor, and assigned a seven percent impairment rating for pain, which is subjective and not based on a clinical or laboratory finding as required by Article 8308-1.03(35). No response was filed by the claimant.

DECISION

We reverse the decision and order of the hearing officer and remand this case to allow a designated doctor to certify MMI and impairment rating and to cure other defects in the prescribed report, as detailed herein.

Claimant, assisted only by his wife, was the sole witness and introduced only one document. He testified, and it was not disputed, that he hurt his lower back on the job on _____, when he lifted a drill bit which weighed between 80 and 100 pounds. He said he had not had any prior back problems, has had constant pain in his lower back, and has not worked since that date. He saw Dr. D, a chiropractor, on the date of his injury and said he has continued to receive treatments from Dr. D about three times each week since his injury except for approximately three weeks. He said he has seen a total of nine doctors, some apparently upon the referral of his treating doctors or referral doctors, and some at the suggestion of "the rehab nurse" (apparently referring to an employee of the carrier or its adjusting firm). He said he saw Dr. H, apparently at the (Institute), upon Dr. D's referral, and that it was Dr. H who first suggested surgery sometime in the November-December 1991 period. Claimant said he told Dr. H he "would think about it." An October 18, 1991 letter from claimant to the Commission stated that he had been seeing Dr. HO, also at the (Institute), that surgery was recommended, that he was not comfortable with that decision, and that he requested approval of a change in physicians. He said he had also been seen by Dr. W and by Dr. M--at the request of the "rehab nurse"--who also recommended surgery, but that he declined surgery considering it "too risky." However, he did say he would still consider surgery if his condition worsens. Claimant said that injections by Dr. HO did not help, that "nothing has helped," and that he "just takes pills to relax and

sleep." Claimant said that he was worse in November 1991 than immediately after the injury, was getting worse, and is now worse than a year ago. He was not getting any better when he saw (Dr. V) at the carrier's request in January 1992, or when he saw Dr. M on March 5, 1992.

Claimant's sole exhibit was a single page document entitled Report of Medical Evaluation (TWCC-69), unaccompanied by any other documents, purporting to bear the signature of Dr. R (with the initials "LR" beneath the signature). We have previously held that the signature of the doctor is an essential requirement for the certification of MMI. See Texas Workers' Compensation Commission Appeal No. 92027, decided March 27, 1992; Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.1(c)(4) (Rule 130.1(c)(4)). In Item 13 of the TWCC-69, which calls for a narrative history of claimant's medical condition including, but not limited to, the onset and course of his medical condition, findings of previous examinations, treatments, and responses to treatments, and a description of the most recent clinical evaluation, appeared the following entry: "Pt has reached MMI. And (sic) in total agreement with [Dr. C] impairment rating of 18% as of 7-22-92." In Item 14 the report stated that claimant reached MMI on "7-22-92" with a whole body impairment rating of 18%. The remainder of Item 14 calling for the documentation of objective laboratory or clinical finding of impairment was blank, as was Item 15 requiring the listing of the specific body part/system and rating if the impairment rating is five percent or greater. Carrier objected to the admission of the exhibit stating that not only was it partially incomplete, but that carrier would show it to be invalid. The hearing officer, however, summarily admitted the document without further development of carrier's objections and commented, "I have a feeling I know what the objection is going to be, having run into," and that "there's several other objections potentially to this, although they could be cured." The carrier did not, however, pursue the admissibility of the exhibit as an appealed issue. We have previously stated that "where there are problems concerning a report of a designated doctor, the hearing officer can appropriately effectuate corrective action" (and might well advisedly do so). Texas Workers' Compensation Commission Appeal No. 93045, decided March 3, 1993; Texas Workers' Compensation Commission Appeal No. 93095, decided March 19, 1993.

The carrier introduced an assortment of miscellaneous documents including medical records from various doctors, some of which appear to be portions of the records of doctors who treated claimant, and reports of other doctors who only examined him. Among such exhibits were Commission documents indicating that claimant had disagreed with an 11% impairment rating (apparently that of Dr. V), and that Dr. R was then selected by the Commission as the designated doctor to resolve whether MMI has been reached and, if so, to assign an impairment rating.

The carrier also introduced a deposition upon written questions of Dr. R to which were appended certain medical reports neither identified nor alluded to by Dr. R in his deposition. Among those reports were the TWCC-69 of Dr. R, various notes concerning

claimant's treatment by Drs. H and HO, and a two-page narrative report, dated July 22, 1992, by Dr. C. Apparently, Drs. H, HO, R, and C were all associated with the (Institute) in either its (City 1) or (City 2), Texas, clinics. (The record is not at all clear as to whether either Dr. H or Dr. HO became claimant's treating doctor upon referral from Dr. D and, if so, whether such relationship was discontinued at some time before Dr. R was selected as the designated doctor.) Dr. C's report contained a history of claimant's injury and commented: "He has refused surgery, and so is therefore considered at MMI at this point, until such time as he feels the need to pursue surgery later. Therefore, we consider him at MMI since his impairment will not change probably more than 3 percentage points either way over the next year." Dr. C's report further stated that claimant has lumbar stenosis and degenerative disc disease, and said he gave claimant seven percent impairment for the specific spinal disorder, 11% for loss of lumbar spine range of motion (ROM), and one percent for neurologic dysfunction (decreased sensation involving the right medial foot consistent with an L5 nerve impairment), for a combined whole person impairment rating of 18%.

Among the documents appended to Dr R's deposition was a July 22, 1992 note of Dr. R which said, in part, that claimant had come in that day to question his 11% impairment rating (from (OPT) which had also been questioned by Dr. V who on her TWCC-69 stated the rating as 11% but in her accompanying narrative report questioned the 11% and recommended 28%). Dr. R's note went on to state: "I have recommended that [Dr. C], an industrial medicine physician working in our clinic, do the evaluation today. The patient has been cared for by [Dr. H] and I have no previous experience in taking care of this patient. I think it would be fair for [Dr. C] to perform this evaluation and I have recommended that he do so today. I am not going to charge the patient for his visit to me today."

In his deposition, Dr. R stated: "The impairment rating was performed by [Dr. C], not by myself. I reviewed the findings and I found that they did comply with the AMA Guidelines to Evaluation of Permanent Impairment." Though in earlier questions Dr. R stated he was familiar with and had previously used the third edition, second printing, dated February 1989, of the AMA Guides (required by Article 8308-4.24), when asked what edition of the AMA Guides he used with reference to claimant, Dr. R responded: "The 1990 guidelines were utilized to evaluate the impairment." Dr. R also said that Dr. C did the ROM testing and further stated that claimant's impairment rating included seven percent "for pain." When asked how he arrived at an impairment rating for pain, Dr. R responded: "I would refer you to [Dr. C] who actually performed the study to answer this question." As mentioned above, Dr. C assigned a seven percent impairment rating for claimant's specific spinal disorder and did not mention in his report any additional impairment rating for pain as such. While Dr. R stated that his report did contain a narrative history of claimant's medical condition, including the onset and course of his condition, a "partial history" of previous examinations and treatments, and the results of the most recent clinical evaluation (which Dr. R detailed from Dr. C's report and other records), he also said it did not contain a statement of the date claimant reached MMI. As earlier noted, however, Dr. R's TWCC-69 did contain an MMI date of 7-22-92 but did not contain the other data. However, it is apparent that Dr. R was referring to Dr. C's report in responding to those questions, and he had stated on his TWCC-

69 he was in total agreement with Dr. C's 18% impairment rating. Dr. C's report could fairly be treated as having been adopted by Dr. R and incorporated by reference into Dr. R's TWCC-69.

Dr. R was also asked on written deposition the date he personally examined claimant and he responded that he examined claimant on July 22, 1992. The hearing officer asked claimant whether he actually saw Dr. R or Dr. C and claimant responded said that "both doctors were there," indicating he "saw" both doctors the same day. Claimant testified there were two doctors there and they called him in and did all the evaluation on him. He said that one of the doctors was "[Dr. C]" and that he didn't know the other doctor's name. Claimant also said he would not disagree that it was Dr. C that did the rating. He further testified that it was Dr. C who took his history, questioned him, and performed the testing. Claimant said he agreed with the 18% rating, which is what he said he wanted from the hearing, and he expressed no disagreement with the MMI date of July 22, 1992.

The carrier introduced a TWCC-69 signed by Dr. V which stated that claimant reached MMI on "5-14-92" and which assigned him an impairment rating of 11%. Attached to Dr. V's TWCC-69 was her June 14, 1992 narrative report which referenced the 11% impairment rating given claimant by OPT, to whom she had referred claimant on March 30, 1992, for a functional capacity evaluation and an "AMA impairment rating." The claimant, incidentally, testified that OPT did all the testing and that Dr. V "didn't do anything to me" and "didn't even touch me." Referring to certain "invalid" straight leg raising test results obtained by OPT, Dr. V commented that OPT was unable to include claimant's "severe limitations in lumbar spine flexion and extension" in their 11% rating, and that had they been able to use such measurements, claimant would have had a total rating of 28%, including five percent for a specific spinal disorder. She, too, felt that as long as claimant refused surgery, he has reached MMI. She stated that had claimant undergone surgery earlier, he may have avoided his chronic pain syndrome, but that he is now in "full chronic pain syndrome" which surgery may not sufficiently reverse to allow his return to work. Dr. V believes claimant's "functional disability" to be "far greater than his simple spine impairment would suggest."

The hearing officer found that Dr. R was appointed as the designated doctor, that "[Dr. C], an associate of Dr. R, filed a TWCC-69 certifying Claimant as reaching [MMI] on July 22, 1992, with an 18% whole body impairment rating," and that such report "reflects Dr. R's own professional opinion and was adopted by him." Finding further that the great weight of the "other evidence" was not to the contrary, the hearing officer accorded the report presumptive weight and concluded that claimant reached MMI on July 22, 1992, with an 18% whole body impairment rating.

Contrary to the hearing officer's finding, the record before us does not show that Dr. C filed a TWCC-69. As for the report of the designated doctor, we view it as sufficiently defective that it cannot be considered a "certification" of claimant's having reached MMI and of his impairment rating. Rule 130.6(g) provides that the designated doctor shall complete

and file the medical evaluation report in accordance with Rule 130.1, which contains the requirements for the content and filing of such report including the requirement that all certifications of impairment be made in compliance with the version of the AMA Guides mandated by Article 8308-4.24. Dr. R clearly stated under oath that the 1990 edition of the AMA Guides was used in claimant's evaluation, while also indicating he was familiar with and had previously used the mandated version. The hearing officer, in his discussion of the evidence, stated that "[a]lthough [Dr. R] may have become confused in his deposition, it appears that [Dr. C] did in fact use the correct version of the AMA guidelines in assigning an impairment rating to Claimant." The hearing officer noted that among the carrier's exhibits were copies of the charts used by Dr. C in assessing claimant's impairment at 18%, that those charts clearly bear the name of the (Institute), and that they have typed on them the following: "Adapted from the American Medical Association "Guides to the Evaluation of Permanent Impairment" second printing of the Third Edition." Such charts are among the miscellaneous documents introduced by the carrier and one of them shows the seven percent, 11%, one percent and 18% impairment ratings referred to in Dr. C's narrative report. We could speculate but cannot know from the record, however, the source of the charts, nor can we know what was meant by the reference, "adapted from" the AMA Guides which appears on the charts. Further, it was Dr. R and not Dr. C who was selected as the designated doctor and we are faced with Dr. R's sworn statement in his deposition that the 1990 AMA Guides were used, notwithstanding the hearing officer's speculation that Dr. R "may have become confused at his deposition."

In Texas Workers' Compensation Commission Appeal No. 92627, decided January 7, 1993, we considered similar problems with the validity of the designated doctor's report, including the carrier's assertion it was not based on the mandated version of the AMA Guides. Because an issue arose at the hearing as to whether the mandated version of the AMA Guides was used by the designated doctor, we found it necessary, given the state of the evidence, that the TWCC-69, or a narrative appended thereto, clarify that the proper edition was indeed used by the designated doctor in arriving at the ultimate impairment rating assigned the claimant, and we remanded for that purpose. We are constrained to do likewise in this case.

The carrier in Appeal No. 92627, *supra*, also complained that the designated doctor had referred the claimant to a rehabilitation hospital for an impairment assessment. In that regard, we said: "We are not willing to say that a designated doctor could not consult with other, qualified experts in making a determination of impairment. However, as with medical reports and the findings of previous examinations by other doctors, the designated doctor must evaluate the findings and recommendations of other experts in developing a recommendation that is ultimately based upon his own professional opinion; he cannot abdicate this role to another." Here Dr. R's TWCC-69 stated that claimant reached MMI on "7-22-92" and unqualifiedly agreed with the 18% impairment rating determined by Dr. C, his associate. Dr. R apparently was present for all or some portion of claimant's examination and testing by Dr. C. Dr. R responded in his deposition that he personally examined claimant, albeit claimant testified that it was Dr. C who took the history, did the testing, and

made the evaluation. *Compare* Texas Workers' Compensation Commission Appeal No. 93095, *supra*, where we stressed the importance of examination by the designated doctor and remanded for the further development of the evidence on that matter.

Based on all the foregoing, we reverse the decision and order of the hearing officer. This case is remanded to assure compliance with the rules on designated doctors, to obtain the designated doctor's certification of MMI and an impairment rating, to confirm whether the designated doctor used the statutorily mandated version of the AMA Guides in determining the impairment rating he assigned to claimant, and to take such other steps as the hearing officer determines appropriate, including such further development of the evidence and further consideration as deemed necessary, for a proper disposition of this case.

A final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Texas Workers' Compensation Commission's division of hearings, pursuant to Article 8308-6.41. See Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Philip F. O'Neill
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Lynda H. Nesenholtz
Appeals Judge